Child Mental Health – Best Practice

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Systems of Care

The State Plan requires that services to target populations reflect best practice. Accordingly, services for children and their families should be defined by outcomes that demonstrate (Surgeon General Report, 1999, President's New Freedom Commission, 2002) "achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; meet developmental milestones, function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (Hoagwood et al., 1996)". Further, because children are not little adults, their services must be planned and delivered in the context of their social environments of family, peer group and schools/work and their larger physical and cultural surroundings. This is particularly true for children with moderate and severe emotional disturbances - diagnosed mental health problems that substantially disrupt a child's ability to function socially, academically, and emotionally.

The State Plan requires that services be provided and developed within a family-centered and strengths-based orientation, promoting community-based comprehensive responses for children with complex and significant functional impairment due to mental, emotional and behavioral problems, and their families. The concept of family-centered and comprehensive care is the

foundation of all system efforts and best practice models for children and their families (President's New Freedom Commission, 2002).

This approach serves the whole family, not just the child with an emotional disturbance. It is based on flexibility, recognizing that parents and families have strengths for meeting their needs, know their needs best and should not be restricted to a pre-selected list of services. It emphasizes respect for and partnership with families and children in the planning, delivery and evaluation of services and stresses collaboration among the various agencies that serve children with the goal of enabling children to live with their families, achieve success in home, schools and community. (President's New Freedom Commission, 2002) This description of child mental health best practice is to provide clarification on these issues as they relate to children with moderate and severe emotional disturbances, and their families. Specifically, it will address:

- Elements of a comprehensive, family-centered orientation as it relates to support and service provision.
- Integration of effective mental health services for children with other agencies that serve them supported and held accountable within a system of best practice.
- Person-centered planning within a wraparound approach that addresses the ecological and developmental context of children's lives.
- Best practice services, interventions and supports that result in meaningful outcomes for children and their families.

Best Practices in Comprehensive Community-Based Support and Services

Achieving meaningful outcomes for children with mental health problems requires that services be delivered within a family-centered and comprehensive care framework. Services must be:

- **Family-centered:** A family-centered approach is embraced across disciplines and settings, recognizing the centrality of the family in the lives of their children. Family-centered services are guided by fully informed choices made by the family and focus on strengths and capabilities of these families. Family-centered care providers acknowledge that each family member influences the family as a whole. Family-centered service providers try to address all challenges that may influence children who need care, meaning that they work with other agencies to provide wrap-around care. Family-centered professionals look for the strengths of each family member and value parental knowledge and experience. (Beach Center on Disability, University of Kansas) http://www.beachcenter.org/frames.php3?id=55&category=Research

- **Wraparound**: Services and supports are planned and delivered in the context of full partnership with the family through wraparound approaches in child and family teams. Community agencies, private providers, family members and advocates then work together to support child and family teams and hold each other accountable for outcomes through local community collaboratives (Burchard, J.D., Bruns, E.J., & Burchard, S.N. (2002) "The Wraparound Approach," in B. Burns & K. Hoagwood (Eds.) *Community-Based Interventions for Children and Families*. Oxford: Oxford University Press).

- **Provided across agencies**: Children needing mental health services may be identified directly by their families; however, they are often identified through one of five distinct types of service sectors: schools, juvenile justice, child welfare, general health and mental health agencies. These agencies have different mandates to serve various groups and to provide somewhat varied levels of services. Many of these agencies arose historically for another purpose, only to recognize later that mental health problems cause, contribute to or are effects of the trouble being addressed (President's New Freedom Commission, 2002 Surgeon General's Report). A comprehensive community-based mental health service system must tackle the problem of service fragmentation. Fragmentation leads to and overuse of costly and largely ineffective out of home placements. Fragmentation must be replaced by creating a coordinated network of services and supports for these children and their families (President's New Freedom Commission, 2002).
- **Culturally responsive and community connected**: A key to the success of mental health programs is how well they use and are connected with established, accepted, credible community supports. The more this is the case, the less likely families view such help as threatening and as carrying stigma; this is particularly true for families who are members of racial and ethnic minority groups (Bentelspacher et al., 1994). Mental health programs attempting to serve diverse populations must incorporate an understanding of culture, traditions, beliefs, and culture-specific family interactions into their design (Dasen et al., 1988) and form working partnerships with communities in order to become successful (Kretzman & McKnight, 1993). Ultimately, the solution offered by professionals and the process of problem resolution or treatment should be consistent with, or at least tolerable to, the natural supportive environments that reflect clients' values and help-seeking behaviors (Lee, 1996).

- **Be outcomes accountable**: Evidence-based clinical interventions are integrated with family supports into a comprehensive plan of care that is individualized for each child and family and that change over time to ensure a goodness of fit. Clinical interventions must be held accountable by functional outcomes that measure a child's success for the child and family at home and school/work and in the community.

Family-Centered Wraparound Approaches as a Unifying Model

The Division requires a family approach to support children and their families. This approach recognizes the importance of the family system and the fact that the services and supports will have an impact on the entire family system. Therefore, the focus of the person-centered planning process is the child/family and recognizes that family members are integral to the development and implementation of the plan. The literature indicates wraparound as best practice for children with serious emotional disturbance and/or substance abuse and their families.

Wraparound is a team approach to children's mental health services that has evolved over the past 15 years through efforts to help families with the most challenging children function more effectively in the community. It was conceived as and is intended to be an alternative to institutionalization and as a response to growing concerns about the ineffectiveness of overly restrictive, categorical mental health and special education services for children with emotional and

behavioral disabilities. More specifically, it is a definable family-centered planning process that results in a unique set of community services and natural supports that are individualized for a child and family in the home, school and community environments to achieve a positive set of outcomes. Rather than being limited by the traditional placements usually offered (i.e., residential, special school, self-contained classroom), the wraparound approach allows providers and families to create individualized plans drawing from people and resources built across the various segments of systems. Supports are built into natural environments – nontraditional providers such as parent partners, student buddies, neighbors, faith-based organizations and volunteers are often part of a wraparound plan for a child and family. Wraparound approaches are universally recognized as identified as best practice in children's mental health (President's New Freedom Commission, 2002, Surgeon General's Report, 1999).

The service structures and practice principles listed below provide the framework necessary for implementation of wraparound – standards of care in services and supports that will help meet the family's needs and the structures within which services and supports are implemented. Operating simultaneously, they provide the primary active ingredients for outcomes-accountable, comprehensive care and treatment:

- Each child and family presents a unique combination of strengths and needs.
- Effective programs build on those strengths as they provide assistance to children and families, respecting culture and family preferences.
- Under wraparound every response will be different, because every child and family is different.
- Each plan of care should reflect and support those differences.
- Providers must be able to identify the functional strengths presented by children and families even when those children and families are experiencing serious problems in their lives. In addition, providers must be able to modify their service options in order to respond quickly and appropriately to the changing needs of each child and family. Furthermore, when children and families have complex needs and are open to several human service systems at the same time, providers must be able to work collaboratively with other individuals and agencies.
- Children and families should have one plan and one team, regardless of the complexity of their needs.

Service and Support Structures

Children with mental health needs and their families need flexible, community-based services that are managed and coordinated as an organized and collaborative service system:

- **Comprehensive plans of care through child and family teams:** Children and their families receive mental health services and supports through child and family teams (one family/one team/one plan), using person-centered and wraparound approaches. Comprehensive plans of care are authorized through the family's child and family team, regardless of where the child is residing.

- **Local decision-making and shared accountability**: Community collaboratives with broad representation across agencies/providers, families and community manage the overall wraparound process and establish the local vision and mission. Collaboratives provide shared leadership, support, responsibility and accountability for implementation of their community's service system. Participants are intricately involved in the development and implementation of their child and family teams and provider network and help ensure quality standards for care and outcomes.

- **Service array and access**: Children and their families have access to an accessible and comprehensive array of mental health/behavioral services, sufficient to ensure that they receive the treatment they need. A lead organization or a network of organizations delivering services is accountable to the community collaborative structure, which manages the implementation of the wraparound process. The array of services includes those provided in family's homes, in their children's schools and in other community locations as needed by the family. Treatment or resource coordinators assist the family, through their child and family team to access services and supports. Mental health services are adapted or created when they are needed but not available. The community collaborative structure reviews the plans.
- **Connection to natural/social supports:** The child and family team with assistance from the community collaborative identifies, promotes and appropriately utilizes natural supports available from the child and parents' own network of associates including friends and neighbors and from community organizations such as service and religious organizations.

- **Assessment:** Evidence based intervention begins with timely and accurate assessment of mental health needs using psychometrically valid and culturally instruments. Assessment instruments paint a picture of a child and family at a given moment in time. Whenever possible agencies doing assessment should try to get information from earlier assessments done by other agencies in order to get an accurate picture of the child.

Standards of Care

- **Collaboration with the child and family**: Respect for and active collaboration with the child and parents is the cornerstone to achieving meaningful outcomes. Families must be full and active partners in every level of the wraparound process. Parents and children are treated as partners in the assessment process, and the planning, delivery and evaluation of services and their preferences are taken seriously. Services include support and training for parents in meeting their child's mental health needs and support and training for children in self-management. Comprehensive plans of care identify parents' and children's need for training and support to participate as partners in the assessment process and in the planning, delivery and evaluation of services and provide that such training and support, including advance discussions and help with understanding written materials.

- **Functional outcomes**: Outcomes must be determined and measured for the system, for the program and for the individual child and family. Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety and permanence in home, school and community.

Services are designed and implemented to aid children to live with their families or in the most family-like setting, achieve success in school, avoid delinquency and become stable and productive adults. Implementation of a comprehensive plan of care stabilizes the child's condition and addresses any safety risks. Psychometrically valid and culturally sensitive assessment instruments should measure outcomes.

- **Collaboration with others**: The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized plan. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established plan of care is collaboratively implemented. Family-centered child and family teams plan and deliver services. Each child and family team includes the child and parents or caretaker, and any individual important in the child's life that is invited to participate by the child or parents. The team is lead by the parent/caretaker and a treatment/resource coordinator who is responsible to the team for planning, implementation and monitoring. The team includes any other persons needed to develop an effective plan, including, as appropriate, representatives from government agencies and the schools. The team (a) develops a common assessment of the child and family's strengths and needs, (b) develops a comprehensive plan of care, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.

- **Best practices**: Mental health services must be provided by competent individuals who are adequately trained and supervised, incorporate evidence-based interventions and are held accountable to provide services within best practices. There must be an unconditional commitment to serve children and their families. Comprehensive plans of care are continuously evaluated and modified to achieving outcomes, rather than ejecting the child or family from care or moving the child to multiple out of home placements.

- **Services tailored to the child and family**: Child and family teams must have flexible approaches and adequate and flexible funding to ensure that the unique strengths and needs of children and their families dictate the type, mix and intensity of services provided. Comprehensive plans of care reflect a balance of formal services and informal community and family supports. Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school and community. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking and what services they think are required to meet these goals.

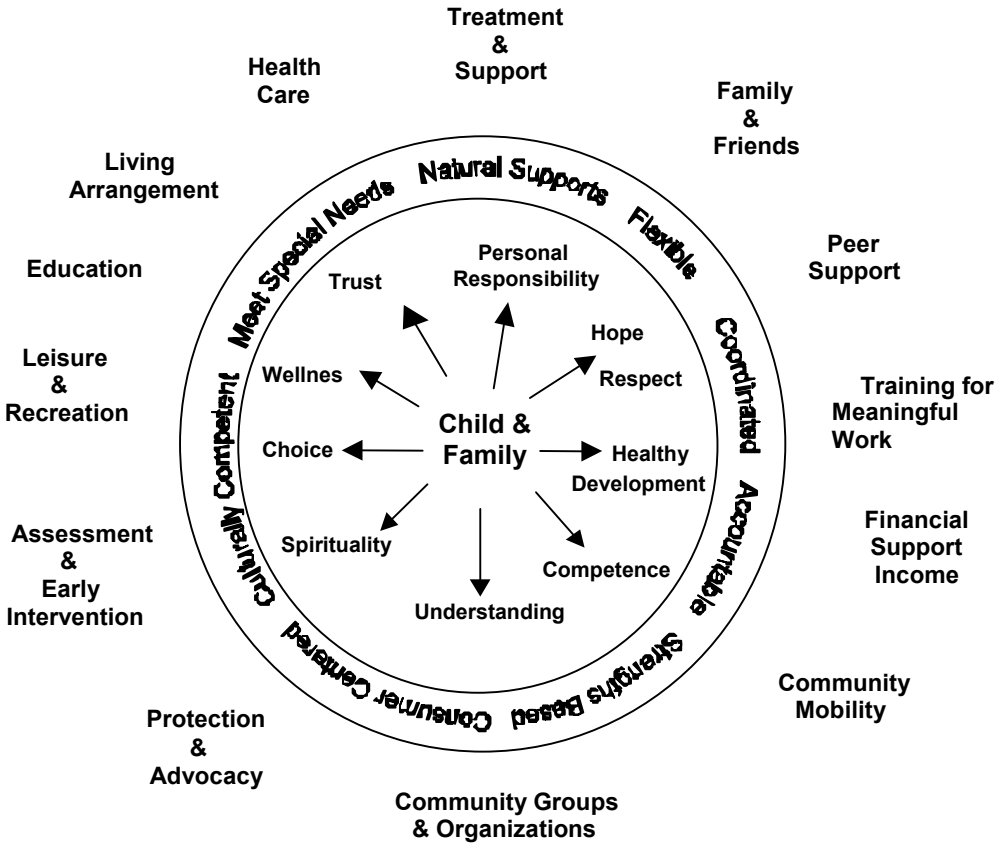
- **Stability**: Child and family teams strive to keep the child with his/her family, in his/her school and community. If a child is at risk of placement out of home, comprehensive plans of care identify steps to be taken to minimize or eliminate the risk. Child and family teams anticipate safety concerns or crises that might develop and include specific strategies and services that will be employed to address them. In responding to safety concerns or crises, all appropriate services will be used to help the child remain at home, minimize placement disruptions (if the child is already placed out of the home) and avoid the inappropriate use of law enforcement or the criminal justice system. Out of home placements for children with mental health needs are a last resort, used only for safety and treatment purposes that

relate directly to measurable outcomes, with concrete plans to bring them back to a stable/permanent home, their schools and community.

- **Transitions**: Comprehensive plans of care anticipate and appropriately plan for transitions in children's and their family's lives, including transitions out of wraparound services as well as transitions to new schools and transitions to adult services.

- **Respect for the child and family's unique cultural heritage**: The process must be culturally competent, building on the unique values, preferences and strengths of children and families and their communities. Mental health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

The illustration below shows the way in which the concept of wraparound for children with mental health/behavioral needs and their families is essential to implementing reforms that are consistent with the State Plan vision and principles.



Best Practice Supports and Services

There is remarkable consensus around best practice supports and services for children with mental health and behavioral problems and their families. Those best practice services that have empirical evidence of efficacy are considered to be evidence-based practice. A recent publication by Barbara Burns and Kimberly Hoagwood, *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders*, provides an overview and details. The Center for Mental Health Services, through annual reports on the National Evaluation to Congress and through their *Promising Practices for Systems of Care* monograph series, describes current and emerging research supporting best practices for children and their families. Additional best practice information is provided in the Surgeon General's Call to Action report on Child Mental Health and through reports of the President's New Freedom Commission. There is consensus across these publications that is reflected in this document.

It is the intent of the Division that the services identified through these documents are a priority. LMEs should utilize these materials for training and in the development of services, supports and integrated systems and utilize associated evaluation tools through the LMEs quality improvement responsibility to ensure fidelity to the model of service throughout the provider network.

The following breaks out the type of service and support array that should be available to children in an integrated service delivery system. The array is divided into three categories based on the role that the LME/mental health providers/Division of MH/DD/SAS has in this integrated system.

Things Mental Health Manages/Does	Things Mental Health Does in Collaboration with Others	Things Mental Health Promotes, Connects to and or Supports
Case management	School-based mental health services	Education, including early childhood
Intensive home-based family interventions	Integrated crisis response	Legal services
Community psychiatry	Positive behavioral intervention and supports (and school based wrap-around)	Protection and advocacy
Social skills/problem solving training	Integrated family support	Recreational activity
Respite care	Independent living supports	Family support and advocacy
Assessment for behavior health needs	Assessment for educational and family functioning	EPSDT and other early childhood health assessments
	Vocational counseling	Peer support and advocacy
	Multi-dimensional treatment foster care	Tutoring
	Early child hood screening	Nurse home visit/ wellness programs
	Treatment courts	Health services

	DSS – multiple response system	Respite cooperatives

A list of best practices for the services in which mental health carries the primary responsibility or directly collaborates is listed on the following pages. Essential elements of a best practice service are listed as well as characteristics of individuals who benefit most from this particular service.

DIMENSION: CASE MANAGEMENT

Case Management

- **Essential Elements**
  - Children and families are linked with all services, benefits and entitlements for which they qualify and that they choose to receive.
  - Case manager participates in and/or leads child and family team planning process with other child serving agencies and stakeholders to develop comprehensive, integrated, family-centered plan.
  - Case manager helps with application process and advocates for entitlements, if child or family experiences a barrier to service or entitlement access, and monitors ongoing connection between child/family and entitlement/service.
  - Case manager also partners with family/child to help connect with natural community supports and resources.
  - Case manager to child ratio is maintained at approximately 1: 12-15.
  - Case management is provided within the context of a partnership relationship; the case manager provides support and problem-solving assistance, as needed.
  - Case management occurs through community-based (rather than office based) contacts.
  - 24/7 crisis response capacity for individuals being provided case management services.
- **Who Benefits**
  - Children with serious emotional disturbances with multiple and/ or complex needs and their families/caregivers.

DIMENSION: MENTAL HEALTH TREATMENT

Intensive Home-Based Family Interventions

- **Essential Elements**
  - Child and family centered strength based mental health interventions emphasizing aggressively managed individualized treatment through person centered planning and delivered in the home.
  - Works with child in context of family to promote real life skills development.
  - Team includes Masters prepared clinician as therapist and case manager and paraprofessional(s) providing one-on-one implementation of the PCP.
  - Clinician specific interventions include: assessment, person centered planning, intensive case management, crisis planning, support, family education, individual and family counseling, life skills development, advocacy, monitoring of support and services purchased.

- 24/365 crisis intervention and management response directly provided by the home based case manager and Para-professional.
- Strengthens connections to informal community resources and natural supports rather than supplanting with Para/professional interventions.
- Interventions may include: all accepted and outcomes-based mental health approaches for children with serious emotional disturbances such as cognitive-behavioral, applied behavioral analysis, family systems, trauma therapy, and coordination with community psychiatry.
- For Substance involved youth, SA assessment and development of dynamic treatment plan.
- For Juvenile Justice involved youth and those with serious anti-social behavior, multi-systemic therapy may be used in the context of the home-based intervention.
- For multi-system involved youth the wraparound approach outlined in this document would apply.
- For children birth to 5 years old with attachment disorder appropriate attachment disorder treatment would be delivered.
- Includes a transition to independence process system (TIPS) to prepare youth and young adults to move into adult roles.

- **Who Benefits**
  - Youth with serious emotional disturbances but especially those with severely inappropriate behavior, with multi-system involvement, and at risk for out of home placement.
  - And for whom there is at least one family member/caregiver who is willing to participate in home based services.

Community Psychiatry

- **Essential Elements**
  - Psychiatrist works as part of multidisciplinary team in a community based program to meet the needs of child consumers.
  - Collaborates with public agencies, consumer groups and family organizations.
  - Understands and works with patients within their sociocultural context and strives for optimal enhancement of functioning and recovery.
  - Strong pubic education role and is source of expertise to colleagues, providers, community, consumers, and families.
  - Participates in development, implementation and support of comprehensive network of mental health services for children.
- **Who Benefits**
  - All children and families served by mental health system.

Assessment for Behavioral Health Needs

- **Essential Elements**
  - Strengths-based tool (for example BERS).
  - Integrated when possible with person/family centered planning process.
  - Looks across life domains and is based on life/family history.
  - Functional assessment approach.

- **Who Benefits**
  - All children seeking mental health services.
  - All children receiving mental health services.
  - Agencies learn how well clients are responding to treatment.

DIMENSION: MENTAL HEALTH INTERVETIONS DELIVERED IN COLLABORATION

Early Childhood Screening (with Public Health, Medical Community)

- **Essential Elements**
  - Children are screened early to prevent developmental and medical problems.
- **Who Benefits**
  - All children seeking mental health services.
  - All children receiving mental health services.

Positive Behavioral Intervention and Supports (with Schools)

- **Essential Elements**
  - Integrates school wide assessment of problem behaviors.
  - Use of behavioral science to institute practical functional based behavioral and academic interventions with all children.
  - While focused on reinforcing positive behavior in all children, PBIS directs more school-based supports from existing school personnel to those who need some additional intervention. Identifies the small number of children who need outside expertise including wraparound services.
  - Individualized support planning.
  - Team-based planning and problem solving.
  - Proactive, outcome driven perspectives.
- **Who Benefits**
  - All school aged children, but especially those with mild behavioral problems.
  - Children with more challenging behavior or at risk for problems.
  - School personnel get a systematic way to access formal mental health services for their most challenging students.

Treatment/Specialty Courts (with Court System)

- **Essential Elements**
  - Integrates family court, juvenile justice and child protective services hearings so decisions about same child are not made discretely from one another.
  - Case management that ensures that a single judge is responsible for all cases involving a given family and judge has access to all appropriate court and other records.
  - Mental health needs seen in context rather than as separate issue.
  - Judge able to remove barriers to cross-agency collaboration that facilitates data sharing, blended funding and cross training.

- Client monitoring is consistent as jurisdiction is maintained over case until resolution.

- **Who Benefits**
  - Children and families with multiple systems involvement.
  - Court personnel get better access to information about clients.
  - DSS, MH and justice personnel answer to one judge on each case.

Multi-dimensional Treatment foster Care (with DSS)

- **Essential Elements**
  - Foster families are recruited, trained, supervised and supported to provide youth with close supervision, fair and consistent limits, predictable consequences and a supportive relationship with an adult.
  - Youth participate in weekly therapy to assist in adjustment.
  - Main treatment effect is expected to occur in the MTFC. PCP/FCP outcome domains are closely monitored.
  - Youth participate in a structured daily behavior management program that outlines activities and expectations.
  - Foster parents have daily phone contact and weekly meetings with support provider/case manager.
  - Family therapy is provided for youth's biological or adoptive families with a focus on problem solving and communication skills, de-escalating family conflict, advocacy training and methods of structured supervision in the MTFC home.
- **Who Benefits**
  - Children and Families for whom intensive home based treatment is not an option at that point, especially those with chronic anti-social behavior, severe emotional disturbance and delinquency.

Multiple Response System (with DSS)

- **Essential Elements**
  - Approaches child protective services through community child protection strategies which apply family support and family centered service principles while not compromising child safety.
  - Allows for more than one type of response to initial reports of child maltreatment.
  - Focused on family centered and strength based assessment and planning process rather than incident-focuses investigative processes alone.
  - When child's safety is not in question, stabilization of family is emphasized to enable parents to better care for children.
  - Child and family team approach used to develop plan of care and service delivery.
- **Who Benefits**
  - Children and Families reported for child maltreatment/neglect.
  - Case managers able to emphasize family strengthening, service delivery and connection to resources.

Assessment for Educational and Family Functioning

- **Essential Elements**
  - Strengths-based.
  - Integrated when possible with person/family centered planning process and other assessment processes through child serving agencies.
  - Functional assessment approach.
- **Who Benefits**
  - All children seeking mental health services.
  - All children receiving mental health services.

DIMENSION: CRISIS RESPONSE SYSTEM

Integrated Crisis Response System

- **Essential Elements**
  - Crisis plans.
  - Crisis services and hospital diversion.
  - Crisis respite.
  - Community Policing Mental Health (Charlotte pilot program).
  - School-based crisis response.
- **Who Benefits**
  - Community Crisis personnel (MH, DSS, EMT, police, Fire, hospital, etc) are involved, trained and prepared to handle child mental health situations in context of system of care principles.
  - Individuals who experience a mental health crisis.

DIMENSION: REHABILITATION SERVICES

Vocational Counseling and Independent Living Supports

- **Essential Elements**
  - Begins with middle school aged child and continues though transition to independence.
  - Establishing a partnership between service provider and consumer.
  - Helping the consumer choose a role and setting in which s/he would like to live, learn or work.
  - Identifying the skills and resources needed to be successful.
  - Helping the consumer learn the skills needed to reach goals & linking the person with the support/resources needed for success.
  - Can be done individually or in groups.
  - Should occur over several months.
- **Who Benefits**

- Individuals with severe emotional disturbances with interest in employment, independent living, and/or education.

Social Skills Training

- **Essential Elements**
  - Is not a "stand alone" service, as it co-exists within the comprehensive case management models of practice (e.g. Intensive In-Home, MST and Community Support Team).
  - Training is based on a documented curriculum that is developed by the Child and Family Team and utilized as a strategy in the PCP.
  - Utilizes a curriculum, which is a task analysis, typically a social task analysis intended to teach a specific skill or set of skills such as good decision making, relationship between cause and effect, how to make friends and be a friend, how not to get kicked off the football team, etc.
  - Is individualized for each youth served.
  - Modeling, role playing, positive and corrective feedback, homework use social learning principles to teach social skills.
  - Involves multiple weekly sessions to implement the individualized curriculum and is evaluated regularly for achievement of the intended outcomes.
  - The individual responsible for implementing the curriculum participates in the PCP process.
  - Individual and group formats.
  - Training lasts 3 months to over a year as long as intended outcomes are being achieved.
  - Training occurs in client's natural setting.
- **Who Benefits**
  - Individuals with schizophrenia who have poor social functioning.

DIMENSION: FAMILY AND COMMUNITY SUPPORT

Integrated Family Support

- **Essential Elements**
  - Services are provided in the context of partnership with family and natural community supports and include things like:
    - Family to family support.
    - Health services.
    - Independent living support.
    - Respite care.
    - Intensive home based counseling.
    - Peer and family support groups.
    - Advocacy training and support.
    - Psycho-social education.
  - Services are integrated with DSS, Courts, DJJDP, Schools and other stakeholders where possible.

- Match parents with trained/experienced peers while also providing education/technical assistance and support in group setting.
- Key element of psychoeducation is its focus: must be on expectations and common goal setting, social and clinical needs, education needs, communication needs, family strengths and weaknesses, stress-reduction, problem-solving, coping, crisis plans, skills training, and other support.
- Oriented to future, not to past.

- **Who Benefits**
  - Children and families with time and resource intensive needs: emotional support, case management, financial assistance, advocacy, housing, etc.

Respite Care

- **Essential Elements**
  - Temporary care for children with disabilities.
  - Trained providers offer relief and much needed breaks for full-time caregivers.
  - May be provided in the home, or in a group setting such as a group home, childcare center or a residential center.
  - Care is in partnership with family that includes clear expectations and guidelines.
  - Respite care is not a substitute for appropriate social and community interaction or regular child care services.
  - Respite provider is trained to provide care including skills for emergencies, but need not be professional.
- **Who Benefits**
  - Children who are at risk for out-of-home placement.
  - Families who face the possibility of having to place a child in an out-of-home setting.

DIMENSION: PEER SUPPORT

Peer Support

- **Essential Elements**
  - Child Peer Consumers share support, hope, skills and problem solving strategies with other consumers.
  - Voluntary and consumer run, with guidance of consumer/family organizations.
- **Who Benefits**
  - Children connect with others around recovery and have opportunity to share their experiences and helping others.
  - Research has shown that members of mutual support groups report increased hope and self-understanding, longer community tenure, increased social integration.

Other Critical Areas

The following areas should also be provided particular attention as part of the supports and services for children with serious emotional disturbances or severe and persistent mental illness.

- **Psychiatric inpatient**: Best practice models include alternatives to episodes of inpatient psychiatric care. Individuals may require psychiatric hospitalizations. It is imperative that the process of discharge planning initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's discharge (continued family support and counseling, as a key example). Furthermore, the discharge itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon discharge. The person-centered plan crisis contingency component should address episodes of inpatient psychiatric care – from admission to discharge.

- **Brief out of home placements**: Best practice models such as wraparound services act as alternatives to treating children in residential settings. There are situations in which treatment while remaining in the home is not possible and may require placement in a residential treatment facility. Other community and home based models of treatment delivery should be explored first, guided by a "no-eject no-reject" philosophy. Out-of home placement should be planned to only be as long as needed to reach safety and treatment goals and should be delivered in the least restrictive setting. As with hospitalization, it is imperative that the process of planning for return to the home (or for some children a foster home/adoption placement situation) initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's return (continued family support and counseling, as a key example). Furthermore, the return itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon leaving the residential facility.

- **Monitoring of medications**: When medications are indicated as part of the treatment plan consumers and families should have access to quality assessment and diagnosis, appropriate algorithm use and consumer/family psycho-social and or medication education, so that families/consumers can advocate well with medical personnel regarding their medications.